STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

October 29, 2018

Mr. Bimal Patal, Administrator
Hartford Hospital
80 Seymour Street
Hartford, CT 06102

Dear Mr. Patal:

This is an amended edition of the violation letter originally dated October 18, 2018.

Unannounced visits were made to Hartford Hospital concluding on September 17, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by November 1, 2018.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by **November 1, 2018** or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

An office conference has been scheduled for **November 8, 2018 at 9:30 AM** in the Facility Licensing and Investigations

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Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Susan Newton, RN., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:jf

Complaints #23335, #23682, #23670, #22246, #22420, #22645, #22576, #23628, #22784, #22162, #23409, #22900, #22526, #23419, #21936, #21966, #22654, #21844, #22601, #22362, #23238, #23600, #22412, #22893, #22658, #21912, #23379, #23770 and #23817

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1)

1. Based on a review of clinical records, interview and policy review, for two of three patients reviewed for care and services provided in the emergency room (Patient #7 and #22) the hospital failed to ensure the patient was assessed prior to discharge and/or that the patient's pain was addressed in accordance with policy. The findings include the following:
   a. Patient #7 presented to the ED on 2/4/18 at 6:10 PM with complaints of altered mental status and near syncope after a fall. The patient sustained a laceration of his/her right arm and had complaints of left arm and buttock pain. The record reflected that the patient rated his/her pain level as a 10, on a 1-10 scale, with 10 being the worst possible pain. At 6:18 PM. Review of PA #1's assessment at 6:30 PM indicated that the patient was alert, had mildly slurred speech, and admits to alcohol use. The patient had a 3 centimeter laceration to the medial aspect of the elbow with full range of motion. X-rays of the pelvis, chest and elbow were negative for fracture.

      A nurse's note dated 2/4/18 at 7:29 PM indicated that the patient attempted to leave prior to seeing the physician and since the patient had an altered mental status this RN did not feel comfortable letting patient leave. Security was called, the patient became physical, punching the security guard in the face. Hartford Police was present in the ED and secured the patient to the stretcher with handcuffs. The PA note dated 2/4/18 at 7:53 PM indicated that the patient was observed ambulating out of the ED accompanied by an officer.

      Interview and review of the clinical record with RN #5 on 6/12/18 at 10:30 AM stated that the patient was initially calm and cooperative, blood work, x-rays and vital signs were completed, however, the patient became combative and security was called. The RN indicated she saw the provider with the patient and was not sure what happened after she left the area. The record failed to reflect that the patient's pain was addressed and/or was re-assessed prior to discharge.

      Review of the Documentation Guidelines directed that the assigned nurse is responsible for the completion of accurate documentation which includes, in part, appropriate clinical assessments prior to discharge and reassessment of pain.

      Review of the Patient Rights Regarding Pain Management policy identified in part, that the patient has the right to appropriate assessments and management of pain. If pain is identified as a problem, a comprehensive pain assessment will be performed. If the patient's pain intensity is unacceptable to the patient, there will be an intervention to reduce the pain.
   b. Patient #22 presented to the ED on 7/7/17 at 10:16 PM with complaints of abdominal pain. The patient was triaged as a level three acuity. Vital signs were obtained at 10:28 PM and the patient rated pain level as a 10, on a 1-10 scale, with 10 being the worst possible pain. The patient was assessed by the PA at 11:38 PM. Review of the PA's note identified that the patient's abdomen was soft, diffuse tenderness, normal bowel sounds, no rebound

tenderness, rigidity or guarding. The patient stated that the pain lasts for a few seconds then goes away, felt like cramping twisting sensation, no nausea, vomiting or diarrhea. Review of the clinical record during the period of 10:28 PM through 1:23 AM failed to reflect that the patient's pain level was addressed.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (e) Nursing Services (1)

2. Based on clinical record review, facility documentation and interviews for one of three sampled patients (Patient #30) reviewed for pain management in the emergency department (ED), the facility failed to ensure that the patient's pain was assessed according to facility protocol. The findings include:
    a. Patient (PT) #30 was admitted to the ED for back and neck pain on 5/31/18, arrival time 3:19 PM. A triage status pain assessment at 3:28 PM identified a pain level of 10 (pain scale 0-10). A physicians order at 3:53 PM directed Tramadol tablet 50mgs. The ED medication administration note identified Tramadol 50mgs given at 3:59 PM. Review of the clinical record failed to identify documentation of pain administration effectiveness and further management of the patient's pain.

    In an interview on 6/21/18 at 11:00 AM, RN#9 identified she reassessed PT#30 after administering the Tramadol but failed to document this. RN#9 identified that PT#30 indicated he/she was still uncomfortable after taking the Tramadol and had informed PA#1of the patient's response. RN#9 further identified PA#1went in to evaluate the patient multiple times but no alternative pain medication or intervention was ordered.

    Review of the facility's Patient Rights Regarding Pain Management policy identified in part that pain will be reassessed after a sufficient amount of time has elapsed for the intervention to reach peak effect but no longer than two hours.

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3. Based on clinical record review, facility documentation and interviews for 2 of 3 sampled patients (Patients #17 and #23) reviewed for intravenous (IV) management, the facility failed to ensure that the IV site was assessed and documented when removed per facility protocol and/or failed to ensure that the IV removal was documented per facility protocol. The findings include:
    a. Patient (PT) #17 was admitted to the ED on 9/27/17 at 5:02PM with chief complaint of chest palpitations.

    Review of the EMS pre-hospital care report dated 9/27/17 identified vascular access left antecubital for IV fluid infusion and IV medication administration. The ED clinical record identified PT#17 was evaluated by the physician, vital signs documented, laboratory tests and diagnostic studies performed. PT#17 was diagnosed with palpitations and discharged

home on 9/28/17 at 4:07AM. Review of the clinical record failed to identify assessment of the IV site and documentation upon removal of the IV prior to discharge.

In an interview on 6/22/18 the ED Manager identified the expectation is for the nurse to document when an IV is removed.

Review of the facility Insertion of a peripheral IV catheter identifies in part to document date and time of removal, reason for removal and condition of IV insertion site in the patient's electronic record.

b. Patient (Pt) #23 presented to the ED with abdominal pain, fever and altered mental status on 1/25/16.

Pt#23's past medical history included peripheral vascular disease, diabetes and CVA with left sided paraplegia.

The ED nurses' note dated 1/25/16 identified an18 gauge IV was inserted into the right antecubital area.

Review of the IV site assessment documentation from 1/25/16 to 1/28/16 identified IV sites left median antecubital area and right median antecubital area.

The documentation identified on 1/28/16 insertion of a 20 gauge IV to the right cephalic vein.

A physician's verbal order dated 1/31/16 directed to keep expired IV site if working.

The patient underwent an aortogram on 2/2/16. Review of the intraoperative record identified insertion of a 22 gauge IV to the right metacarpal. Review of the clinical record identified removal of the 22 gauge IV on 2/3/16.

The IV documentation assessment note dated 2/4/16 identified right cephalic IV site leaking, catheter removed intact. A note dated 2/5/16 identified a 20 gauge IV was inserted into the right cephalic upper arm area with ultrasound.

The clinical record failed to identify documentation for removal of the left and right antecubital IV sites on 1/28/16 and documentation for removal of the right cephalic upper arm IV upon the patient's discharge on 2/6/16.

In an interview on 6/22/18 the Manager (#5)for IV therapy services identified the expectation is for the nurse to document when an IV is removed.

Review of the facility's Insertion of a Peripheral IV catheter policy identified in part to

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document date and time of removal, reason for removal and condition of IV insertion site in the patient's electronic record.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (e) Nursing Services (1)

4. Based on clinical record review, facility documentation and interviews for 1 of 3 sampled residents (Patient #23) reviewed for grievances, the facility failed to ensure that a grievance was resolved according to facility protocol. The findings include:
   a. Patient (Pt) #23 was admitted to the facility on 1/25/16 with a diagnosis of right hydronephrosis. Pt#23's past medical history included peripheral vascular disease, diabetes and CVA with left sided paraplegia.
   On 1/28/16 Pt#23 underwent a cystoscopy, right retrograde pyelogram and an attempted stent placement which was canceled due to the anatomy of the ureter.

   On 2/4/16 Pt#23 underwent a percutaneous nephrostomy tube placement secondary to failed right retrograde stent placement.

   Review of facility documentation with the Director of Regulatory Readiness identified Pt #23 had complained about his/her experience during the procedure dated 2/4/16 and had apprehensions for any other treatment related to the procedure. Facility documentation further identified communication with Pt #23 and patient advocate representatives on 2/5/16, 12/8/16, 5/19/17 and 5/23/17. The facility was unable to provide documentation that the patient's grievance was resolved.

   In an interview on 6/22/18, the Director of Regulatory Readiness, identified a follow up call to Pt#23's concern was attempted and a message left on 5/23/17. The Director of Regulatory Readiness identified no further communication with Pt#23 was available.

   According to the Complaint and Grievance Management policy identified in part that the facility will provide periodic communication with the patient if the resolution will take longer than thirty days. In addition the facility will issue a final letter to include name of contact person, steps taken on behalf of the patient to investigate the grievances and the date of completion.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13- D3 (b) Administration, and/or (c) Medical staff (2) (B), and/or (d) Medical records (3), and/or (e) Nursing service (1), and/or (i) General (6).

5. Based on a review of the clinical record, staff interviews and a review of the hospital policies and procedures for one of three (Patient #18), the facility failed to ensure a safe discharge from the hospital in accordance with the hospital's policies and procedures. The finding included:
   a. Review of the clinical record identified Patient #18 was admitted to the hospital on 8/19/17

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with complaints of abdominal pain who underwent a small bowel resection for an ischemic bowel and lysis of adhesions and was also treated for an acute onset of atrial fibrillation. It was determined the patient could safely discharged from the hospital to home on 8/29/17 with home care services. Review of the physical therapy (PT) notes dated 8/28/17 identified Patient #18 was ambulating with a rolling walker and supervision. When the patient did not have the support of the rolling walker he/she demonstrated decreased stability and furniture walking. PT educated the patient on the importance of a rolling walker. PT recommended that the patient could be discharged to home with a rolling walker, with a plan of the family to transport the patient to home. Patient #18 was discharged to home on 8/29/18 via a taxi service to his/her apartment where the patient resided alone. The patient was not provided a rolling walker at the time of discharge and was without the accompaniment of any individual. Interview with the Director of Case Management on 7/12/18 at 11:45 AM identified that arrangements should have been made for the patient to be discharged with a rolling walker and supervision. The Director of Case Management indicated if the discharge could not be conducted in this manner that a higher level of transportation via a medical service should have been obtained by the case management and was not.

The hospital policy entitled Case Coordination Department Discharge Planning directed in part that the Case Coordinator would assess each patient for post-acute care needs. This process shall involve collaboration with the health care teams, including patient's, significant others, physician's, nursing staff and community contacts as appropriate for care transitions. The policy directs that the Case Coordinator would complete an initial assessment and that any information related to the patient's condition would be documented in the Case Coordination note including current presenting problem, functional status, availability of support systems and potential transition needs. The Case coordinator would re-assess the patient's transition plan on an ongoing basis through clinical care rounds and through discussion with the health care team and determine if there are factors that may affect the appropriateness of the post-acute discharge plan and if so the case Coordinator would modify the plan. Lastly, the Case Coordinator would develop a patient centered care transition that included but was not limited to home health care, outpatient visits and transportation.

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6. Based on a review of the clinical record, staff interviews and a review of the hospital policies and procedures for one of three patients (Patient #33), the facility failed to conduct nursing assessments, and/or failed to document the titration of oxygen, and/or failed to conduct a respiratory assessment following a respiratory treatment in accordance with the hospital's policies and procedures. The findings included:
    b. Review of the clinical record identified Patient #33 was admitted to the Emergency

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Department (ED) on 6/18/18 at 1:39 PM after ingesting food that was thought to be in the esophagus. The patient had a history of an esophageal stricture, asthma, and hypertension. The patient presented with a productive cough and oxygen saturations of 88-90%. Oxygen was administered at 4 liters via nasal cannula. Patient #33 was examined by the physician and found to have bilateral rhonchi with inspiratory and expiratory wheezing. Further review of the physician's progress notes indicated the patient's work of breathing was within normal limits and he/she was not in distress. Imaging was conducted that failed to identify aspiration or pneumonia. Patient #33 was afebrile. The patient was treated with a bronchodilator and oxygenation improved after the treatment and as time progressed. Patient #33 passed an oral trail and oxygen saturations were 95% in room air prior to discharge. Patient #33 was discharged to home on 6/18/18 at 6:39 PM with recommendations to follow up with his/her gastroenterologist and primary care provider.

a.

a. Interview and review of the clinical record with the Interim Director of the ED on 7/17/18 at 2:00 PM indicated that a nursing assessment had not been completed every two hours and prior to discharge on 6/18/18. The patient was triaged and an initial comprehensive nursing assessment was conducted at 1:57 PM. The clinical record failed to reflect that a nursing reassessment was completed at 4:00 PM and/or prior to discharge. The Interim Director indicated nursing assessments were required every two hours and prior to discharge.

b.

b. Interview and review of the clinical record with the Interim Director of the ED on 7/17/18 at 2:10 PM indicated Patient #33 was placed on 4 liters of oxygen on admission for an oxygen saturation of 88%. A nurse's note dated 6/18/18 at 5:10 PM indicated oxygen was administered at two liters. The clinical record also identified at discharge Patient #33 was on room air. The record failed to reflect when the oxygen had been titrated from 4 liters to 2 liters and when it had been discontinued. The Interim Director of Nursing identified that each titration should have been documented with a corresponding respiratory reassessment and/or response following each titration and was not. The hospital policy entitled Emergency Department Documentation Guidelines directed in part that an initial nursing assessment would occur upon assumption of care, reassessments would be conducted every two hours and documented in the medical record. The assigned nurse would be responsible for ensuring the completion of accurate documentation which includes but is not limited to pain assessments, vital signs, all nursing procedures and interventions performed, appropriate clinical assessment prior to discharge or transfer and transfer or discharge note.

c. Interview and review of the clinical record with the Interim Director of the ED on 7/17/18 at 2:25 PM identified a physician's order dated 6/18/18 at 2:11 PM directed albuterol (0.083%) 2.5 mg/3ml nebulizer solution that was administered at 2:53 PM. Further interview with the Interim Director of the ED indicated it was the responsibility of the respiratory therapist who administered the medication to document an assessment and/or response following the treatment and he/she did not. The hospital policy entitled Small Volume Jet Nebulizer Procedure directed in part that the respiratory care practitioner would administer the nebulizer treatment in accordance with the physician's orders. The policy

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further directed that the respiratory therapist would document an assessment, response, and medication administration in the electronic health record.

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7. Based on clinical record review and interviews for 1 (P#8) of 5 patients reviewed for restraints the hospital failed to ensure the medical record documentation was accurate. The findings include:
   a. Patient (P) #8 was admitted to the hospital on 8/3/17 for evaluation of acute on chronic diastolic heart failure in the setting of medication noncompliance and significant depression. A Physicians' order dated 8/8/17 at 2:59 AM indicated P#8 required bilateral soft wrist restraints. However a progress note by the Advanced Practice Registered Nurse (APRN) dated 8/9/17 at 2:51 PM indicated P#8 was placed in 4 point restraints for safety concerns. During a review of the medical record on 6/14/18 at 1:45 PM with Nurse Manager #2 he/she indicated the progress note was not accurate and P#8 had been placed in bilateral soft wrist restraints to obtain an electrocardiogram (EKG) and had not been in 4 point restraints at that time.

      The facility policy for medical record documentation guidelines identified prior to authenticating and accepting as final any entry made into the patient's medical record, the author should verify the identity of the individual's record, accuracy and completeness of the data.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (d) Medical records (3) and/or (e) Nursing Services (1).

8. Based on medical record reviews, review of facility policies, review of facility documentation and interviews, the facility failed to ensure that for one of three patients who received care by the Rapid Response team (Patient #4), the facility failed to ensure that Rapid Response documentation and/or medical record were accurate and/or properly recorded. The finding includes:
   b. Patient #4 had a history of cancer and had a total glossectomy with oral and oropharyngeal reconstructive surgery with tracheostomy on 2/12/18. Notes by RT #1 dated 2/17/18 indicated that she arrived to Patient #4's room at 8:30 PM, the Patient's O2 sats were 50's, was unable to pass the suction catheter and a Rapid Response was called.
      The Rapid Response flow record and/or patient record were reviewed on 6/14/18 and identified that following: 1) the Rapid Response flow record noted that the Rapid Response Team was called at 8:29 PM and in another section of the flow sheet, was called at 8:33 PM 2) scribbling over, instead of a single line through typed or hand- written notations was noted in 6 areas on the flow record 3) four number entries were written over on the flow record instead of crossing out the incorrect number and writing the correct number next to the first entry 4) anesthesia documentation identified intubation initiated at 8:35 PM and the Rapid Response flow record indicated that anesthesia did not arrive until 8:38 PM.

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Interview with the Director of Regulatory Readiness on 6/14/18 at 11:34 AM noted that when she reviewed the Rapid Response flow record she became aware of the documentation issues.

The facility policy for medical record documentation guidelines identified that an incorrect entry should be corrected by drawing a single line through the entry. The policy further directed do not obliterate or otherwise alter the original entry by writing over the entry.

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9. *Based on medical record reviews, review of facility policies, review of facility documentation and interviews for one of three patients who had a tracheostomy and/or received rapid response team care (Patient #4), the facility failed to ensure continued monitoring and/or additional interventions for a period of time during a change in condition. The finding includes:

c. Patient #4 had a history of cancer and had a total glossectomy with oral and oropharyngeal reconstructive surgery with tracheostomy on 2/12/18. MD #15's progress note dated 2/17/18 identified that a #6 tracheostomy tube was in place, secured with straps and the Patient was stable for transfer to the floor. Facility documentation indicated that the Patient was transferred and arrived to BLISS 8 on 2/17/18 at 6:32 PM.

Nursing narratives by RN #7 dated 2/17/18 noted that she was notified via a phone call from the Unit Secretary (8:10 PM) that Patient #4 requested suctioning, instructed that Respiratory (RT #1) be called, arrived to the Patient 6 minutes later (8:16 PM) and was informed that RT #1 would be at bedside as soon as possible. Review of flow sheets and/or nursing narratives dated 2/17/18 identified that RN #7 met resistance twice when suctioning Patient #4 through the tracheostomy, could not advance the catheter to the carina and subsequent to a cough, the Patient's SpO2 sat (peripheral oxygen saturation) rose from 85 to 94% (normal range = 90-100%) documented at 8:18 PM and a respiratory rate was not assessed. Notes by RT #1 dated 2/17/18 indicated that she arrived to Patient #4's room at 8:30 PM (12 minutes after the saturation reading of 94%), the Patient's O2 sats were 50's, was unable to pass the suction catheter and a Rapid Response was called. Patient #4 suffered a cardiorespiratory arrest, anoxic encephalopathy and required mechanical ventilation. Patient #4 was extubated per family wishes and subsequently expired on 2/28/18 at 7:10 AM.

Interview with RN #7 on 6/14/18 at 11:48 AM and/or 6/19/18 at 5:56 PM noted that after she suctioned Patient #4 the Patient did not feel better so she called RT #1 via her phone immediately after suctioning. RN #7 identified that she then left the room to get the Charge Nurse who was just outside of the room and RT #1 arrived within a couple of minutes.

Interview with RN #7 on 6/19/18 at 5:56 PM indicated that after the Patient's O2 sat was

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94% (8:18 PM) she did not recall further O2 sat monitoring and RT #1 was the person who called the Rapid Response. The Charge Nurse did not recall the event. Interview with RT #1 on 6/28/18 at 3:07 PM noted that when RN #7 called her, she came immediately to the Patient's bedside, the time of 8:30 PM for arrival to patient bedside was not too far off and after she could not suction the Patient she began to ventilate the Patient with a bag mask over the mouth and nose.

Interviews and medical record documentation failed to identify additional Patient monitoring and/or interventions to address the Patient's complaint of respiratory difficulty from 8:18 PM to 8:30 PM (12 minutes).

The facility RN job description identified an accountability to appropriately assess, plan and document problems, organizing care and interventions and identifying appropriate resources in order to meet individual needs.

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10. Based on medical record review, review of facility policies and interviews for one of three patients reviewed for patient rights (Patient #2), the facility failed to ensure that the patient's conservator was notified of admission and/or that alternative discharge plans were explored. The finding includes:
    a. Patient #2 had diagnoses that included moderate mental retardation, post-traumatic stress disorder, mood disorder and pervasive developmental disorder (autism). Patient #2 was admitted from the Group Home to the ED on 5/9/18 for a crisis consult following increased agitation and aggression. The ED record dated 5/9/18 identified that a Group Home staff member was present with the Patient in the ED. The record lacked documentation that the Patient had a Conservator and/or that the Conservator was notified of the Patient's admission on 5/9/18. Interview with Person #20 on 6/18/18 at 8:55 AM identified that he/she was not notified by the ED staff of the patient's admission and was later informed by the Group Home. Interview with the Group Home Program Coordinator on 6/19/18 indicated that a staff member always accompanied and stayed with their client until the client was admitted or discharged. He/she further identified that a binder to include, in part, conservatorship documentation was always sent with the patient. Interview with the Director of Regulatory Readiness on 6/19/18 at 9:58 AM noted that she spoke with SW #1, SW #1 recalls a staff member with Patient #2 and could not recall whether or not a binder was sent with the Patient. The Director of Regulatory Readiness further indicated that the Conservator of Patient #2 should be notified of the Patients ED admission. The facility policy for patient rights and responsibilities identified a right to be informed about and participate in care and treatment plans.
    Patient #2's medical record dated 5/9/18 identified that the Patient remained calm in the

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ED from 5/9/18 to 5/11/18 and was evaluated by SW #1 and MD #9 (Psychiatrist). The ED record further noted a plan to discharge the Patient back to the Group Home on 1 to 1 observation and to change the Patient's nightly Depakote 1000mg dose to 250mg 4x/day. Documentation by SW #1 dated 5/11/18 at 2:59 PM noted that Person #20 (Conservator) did not support the Patient's discharge back to the Group Home. The note further indicated that Person #20 was concerned for the safety of other clients in the Group Home, wanted the Patient admitted to the Facility BHU (behavioral health unit) and suggested if discharged, to discharge the patient to the "street or a shelter". Interviews with the Director of Social Services and/or MD #9 on 6/21/18 at 11:39 AM indicated that the Supervisor of DDS (Department of Developmental Services) and the Group Home Staff agreed to take Patient #2 back to the Group home with the 1 to 1 supervision. The interview further noted that DDS and the Group Home could better address Person #1's comments regarding the Patient's discharge. Although MD #9 documented that Patient #2 was not capable of independent living as suggested by Person #20 and had "grave concerns" with the suggestion, alternative measures were not tried when the Hospital could not comply with the Conservator's wishes. The facility Social Service Department was not contacted to explore possible discharge options. The facility policy for patient rights and responsibilities identified a right to be informed about and participate in care and treatment plans. The facility did not have a policy to direct staff in the event that a Conservator's directive could not be followed.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing Services (1) and/or (i) General (6).

11. Based on medical record review, review of facility policies and interviews for one of three patients reviewed for pressure ulcers (Patient #21), the facility failed to ensure that pressure reducing devices were utilized in the chair and/or pressure ulcer assessments were performed as per policy. The finding includes:
    a. Patient #21 was admitted to the hospital from 5/2//17 to 5/9/17 and 5/10/17 to 5/25/17 with complaint of weakness and return of uremic encephalopathy vs infectious etiology and an identified unstageable left hip pressure ulcer. Pressure ulcer protocol was initiated as the nursing plan of care on 5/2/17 and 5/10/17. The wound care consults dated 5/2/17 and 5/11/17 identified an unstageable left hip ulcer vs lesions from scratching and recommended, in part, a low air loss mattress and waffle cushion when in the chair. Review of the Patients EMR (electronic medical record) with APRN #6 (Wound Ostomy Continence Nurse) on 6/18/18 at 9:44 AM indicated that although an air loss mattress was applied to the bed on 5/2/17 and 511/17, a waffle cushion to the chair was not documented as in place when the patient was in the chair for either hospital stay. Interview with APRN #6 on 6/18/18 at 9:44 AM noted that Patient #21 would be a candidate for the waffle cushion when in the chair. The facility policy for pressure ulcer prevention identified to relieve or redistribute pressure with use of pressure reducing mattress and cushion and use appropriate pressure redistribution devices for the chair.

    In addition, wound measurements dated 5/2/17 identified a yellow unstageable left hip

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pressure ulcer that measured 0.6cm (L) by 0.2cm (W) by 0cm (D). Wound measurements dated 5/3/17 identified a yellow unstageable left hip pressure ulcer that measured 2.5cm (L) by 0.4cm (W) by 0.2cm (D). Patient #21 was discharged on 5/9/17 and wound measurements after 5/3/17 to discharge were not documented. Interview with APRN #6 on 5/18/18 at 1:47 PM noted that the next measurement was not due until 5/10/17. The facility policy for assessment, prevention and treatment of wounds and pressure ulcers identified, in part, to note size (measurements for length, width, and depth) weekly and before discharge.

In addition, wound measurements dated 5/11/17 identified a yellow left hip unstageable pressure ulcer that measured 1.2cm (L) by 0.6cm (W) by 0cm (D) with yellow drainage. Physician orders dated 5/11/17 directed a foam dressing every 3rd day to the left hip pressure area. Review of the Patient's EMR with APRN #6 on 6/18/18 identified that although the Patient's foam dressing was due to be changed on 5/18/17 and 5/23/17, the dressing change was not documented. The review also noted that the left hip pressure ulcer, although assessed by nursing, lacked further pressure ulcer measurements after 5/11/17 to discharge on 5/25/17. Interview with APRN #6 on 5/18/18 at 10:36 AM indicated that a foam dressing must be changed every three days and pressure ulcers must be measured at least every 7 days. The facility policy for assessment, prevention and treatment of wounds and pressure ulcers identified, in part, to note size (measurements for length, width, and depth) on initial assessment and weekly. The policy further directed the use of a foam dressing for unstageable pressure ulcers- change every 3 days.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2), and/or (c) Medical staff (2)(B), and/or (d) Medical records (3), and/or (e) Nursing service (1) and/or (i) General (6).

12. Based on a clinical record review, staff interviews and a review of the hospital's policies and procedures for one of three patients reviewed for continuous observation (Patient #36), the hospital failed to monitor the patient in accordance with physician's orders and the hospital policy. The finding included:

    a. Patient #36 was admitted to the Emergency Department (ED), on 7/22/18 at 6:09 PM. The patient was transported to the ED by the Emergency Medical Service (EMS), after he/she was found unresponsive in the community. Further review identified that Narcan 6 milligrams (mg) was administered in the field for a respiratory rate of 4 breaths/minute. Patient # 36's respirations improved and he/she was able to respond to EMS subsequent to the administration of Narcan. On arrival to the ED, Patient #36 was again unresponsive but had an even and unlabored respiratory effort. Additional Narcan was administered in the ED with minimal effect. Review of physician orders dated 7/22/18 at 6:10 PM directed constant observation due to a risk to self and accidental injury. Review of diagnostic testing and imaging identified that ultimately the patient was discharged back to the community on 7/23/18.

    Review of the clinical record and interview with PCA #4 on 9/18/18 at 10:50 AM identified on 7/22/18 at approximately 7:45 PM to 8:00 PM an unknown visitor, who claimed to be the patient's uncle, requested a washcloth to clean the patient as he/she had vomited. PCA #4

indicated she provided the visitor with water and a wash cloth. The visitor closed the curtain and Patient #36 was no longer visible. PCA #4 identified after a few minutes she opened the curtain to check on Patient #36 and found the visitor touching the patient's genitalia.

Interview with PCA #4 indicated the reason she allowed the curtain to be drawn was to provide the patient with privacy while he/she was cleaned by a "family member". Interview with the Interim Director of Nursing on 9/14/18 at 2:00 PM identified PCA #4 should have been in constant visual observation of the patient at all times and was not.

The hospital policy entitled Continuous Observation and Intervention by Nursing directed in part that patients have the right to safe delivery of care and protection from behaviors that place themselves or others at risk of injury. Patients on continuous observation are continuously observed by a staff member and would maintain continual visual monitoring of the patient. The patient would not be left alone or unattended. The patient would not be left alone with the family unless this was indicated in the plan of care. The patient would be observed constantly and physically close.